Transcript Details

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Addressing Myths and Missteps in Uterine Fibroid Care

Announcer:
You're listening to *Advances in Women's Health* on ReachMD, and this episode is sponsored by Sumitomo Pharma. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Advances in Women's Health* on ReachMD, and I'm Dr. Charles Turck. Here with me today to debunk common myths and misperceptions in the management of uterine fibroids is Dr. Ayman Al-Hendy. He's a Professor of Obstetrics and Gynecology and the Director of Translational Research at the University of Chicago Pritzker School of Medicine. Dr. Al-Hendy, welcome to the program.

Dr. Al-Hendy:
Thank you so much for having me to talk about this very important topic.

Dr. Turck:
Well, to start us off, Dr. Al-Hendy, why do some clinicians hesitate to consider gonadotropin-releasing hormone, or GnRH, based therapies for fibroids? And how can we address some of those concerns?

Dr. Al-Hendy:
I would say there are two main reasons for this challenge. One is, historically, we had options working on the same pathway that you mentioned, the gonadotropin- releasing hormone pathway, and the hypothalamic-pituitary-ovarian axis. Those we had, let's say, for the last 20-25 years—things like leuprolide acetate, etc., and others in other countries. Those were, first, by injection only, so there was that element of inconvenience and invasiveness. Second, more importantly, they were GnRH-releasing hormone analogs or agonists. So what does that mean? They would go in into the GnRH-releasing hormone receptor on the pituitary, bind to it, and first stimulate it for about two weeks or so, and then eventually shut it down. And once you shut it down, what happens is the ovary stops producing estrogen and progesterone. And that's the goal because, as you know, fibroids live on estrogen and progesterone. So by depriving them from estrogen and progesterone, they start to shrink, and the patients start to get better.

So the problems with this approach were two things. One, in this initial two weeks, symptoms actually get worse, because these GnRH analog or agonist would bind and stimulate the receptor before it shut it down two weeks later. So there was this flaring effect that made the patient actually get worse. So then imagine a patient coming and complaining of pelvic pain and heavy menstrual bleeding, and we're going to make her worse for two weeks, and then eventually, yes, she will eventually, gradually get better. This made doctors and patients lose interest in this approach of therapy.

The second is because when this medication shuts down the ovary, it shuts it down completely, so there's very little estrogen in the body of the patient. With very little estrogen, the patient will suffer side effects—really important, very annoying, and I would say, serious side effects—things like hot flashes, severe vasomotor symptoms, sweating, especially at night, painful intercourse, and also loss of bone mass. And eventually, if the patient continued to use those old medications for a long time—more than six months or so—they'd actually start to get things like osteoporosis, and they would be at risk for a fracture. So these are serious side effects.

Because of all of that, both patient and doctors lost interest in this pathway, and unfortunately, they start to go straight to surgery. Now, this has totally changed with this new group of medication—the oral GnRH antagonist—things like elagolix and relugolix. Those are the two main options available in the United States. And then another one is called linzagolix—it's available in Europe and other countries and hopefully will be available in the US in the future as well.

These are totally different. These are oral—no need for needles and injection and no need to keep coming to the hospital to get the injection. These are simple prescriptions. The patient can take it, use it in the comfort of their home, and start to enjoy the improvement in symptoms very quickly at home. Second, there's no flaring. Things don't get worse before they get better. So the patients start to see the improvement very quickly. And third, most importantly, in the same treatment tablet, there is also a little bit of estrogen, so the patient doesn't suffer from these side effects like hot flushes, night sweats, and weaker bones. So when you put this all together, these medications are really an important addition to the options we can offer our patients.

Dr. Turck:
And what are the most common misconceptions about hormonal treatment options for uterine fibroids?

Dr. Al-Hendy:
Generally, hormones have a bad image out there—maybe because, as I mentioned earlier, estrogen and progesterone actually make fibroids worse. Now, the treatment that I mentioned a minute ago—the oral GnRH antagonist—elagolix, relugolix, and linzagolix work on the hormonal pathway, but they themselves are not hormones, and the amount of hormones in the patient's body when they are using these medications are less than what an average woman has.

So I tell my patient who might bring this point up—"I don't want to have to do anything with hormones"—I say, actually, with this medication, the amount of estrogen in your body will be actually less than when you are not on this medication. And that's actually how it works. It works by decreasing the estrogen in the body, which would make fibroids suffer, because fibroid love estrogen. So by decreasing the estrogen in the body will make fibroids shrink, and fibroid symptom gets better.

Dr. Turck:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Ayman Al-Hendy about myths and realities in uterine fibroid care.

So, Dr. Al-Hendy, taking a little bit of a closer look at all of our available therapeutic options, how do these different treatment modalities compare in terms of safety and efficacy?

Dr. Al-Hendy:
All these three new medications belong to the same family. And even if you look at their names—elagolix, relugolix, and linzagolix—they all sound similar because they actually are from the same family of compounds. I would say, in benign gynecology or non-malignant gynecology, we were lucky; six to seven years ago, we had no medical treatment options to treat fibroids specifically. We had options that we used just to improve the symptoms, but they really did not attack the disease.

In fact, to be honest, the FDA never in their history—about 120 years or so—approved a medication for treatment of uterine fibroids. There was the leuprolide acetate that I mentioned—it wasn't actually approved to treat fibroids. It was approved to be used in fibroid patients in preparation for surgery. It was just approved to improve the anemia in patients with fibroids who were getting ready to have surgery, such as hysterectomy or myomectomy.

And then in the last six years, we have three medications. In the US, we have two medications approved for treatment of fibroids: elagolix and relugolix. And in Europe, like I said, linzagolix as well. So we have three new options. These three medications work very similarly, and they are all very effective. So I think any of these medications would be great treatment options for patients with uterine fibroids.

Dr. Turck:
Well, speaking to that, what clinical considerations do you have your patients consider when selecting between medical versus procedural interventions?

Dr. Al-Hendy:
I always encourage them to use medical treatment options first and then go to surgery, like any disease. All of us were patients at one point or the other. When you go to the doctor, it would just make sense to start with simple medical treatment options—some kind of a prescription—and then only if those fail, you go to surgery. Unfortunately, in fibroids, the pyramid is upside down because, as I mentioned earlier, many years ago, surgery was the only treatment option. So we got into the habit during training and fellowship and so on that fibroids equal surgery. While this could have been acceptable 20, 30, or 40 years ago, in my opinion, this is not acceptable anymore.

So I always counsel my patient about medical treatment options and tell them all their options, and then I always say, surgery is always available. Surgery is not going to go away. If you're not happy and we don't achieve your goals, we can always move to surgery, but we cannot do it the other way. We cannot do hysterectomy and then go back to other treatment options. So I counsel them about all the

options. I usually start with surgery because that's usually what they have heard about, and I talk about the pros and cons. But then I always talk to them about the medical treatment options. And I would say the majority of patients, if not all the patients, are so happy to know that there are options other than surgery. And to my surprise, even though they come and see me as a second or third opinion, they have never heard and never been counseled about other options other than surgery, which, in my opinion, is unacceptable nowadays with these options FDA approved based on high-quality evidence to treat and help fibroid patients.

Dr. Turck:
Now, once a patient begins their treatment, what role does education play during their healthcare journey in overcoming misconceptions and ensuring adherence?

Dr. Al-Hendy:
That's a great point because many of the patients come from the area of surgery, and they have been counseled. Okay, let's just take the uterus out, and then your problem is going to be over and you don't have to worry about fibroids anymore. Unfortunately, they are not told in the same counseling session about the possibility of short-term and long-term complications of hysterectomy. And again, I'm a surgeon, but I always like to do what's best for the patient and try with simple approaches, and then leave surgery as the last resort.

So coming from this concept, that one and done, to a medical treatment option, to a medication they have to take every day and so on, they need to be educated. They need to be counseled about how this is a journey, that fibroid is a chronic disease. It's not like sore throat where you take an antibiotic for three to four days, and then you are cured. It is, unfortunately, a disease that's probably going to stay with you until you reach menopause with the average age of 52. So if you stop the medication, the symptoms of fibroid will come back.

However, the medications are very easy to use, very well tolerated, and have minimal or no side effects, and you can stay on it as long as you need to achieve your goal. So if your goal is to reach menopause, these medications are a great way to bridge you into menopause. Once you hit menopause, you can stop. Your fibroid issue is behind you. It's gone. Or if your goal is to achieve pregnancy, but maybe you're not ready right now, we can use the medication to shrink the fibroid, improve your symptoms, and improve your quality of life. Once you're ready to build your family, we can stop the medication, and then you will have a nice window before fibroid symptoms come back, and you can try to achieve pregnancy during that time, and etc., for other scenarios.

So it's important to counsel the patient that this is a journey. Yes, hysterectomy is once and you're done, but hysterectomy comes with a potential high risk of complications and issues after the surgery. So all of this should be discussed, and then the patient will decide what's best for her.

Dr. Turck:
Lastly, Dr. Al-Hendy, would you share one key message you'd like clinicians to take away with regard to uterine fibroid care?

Dr. Al-Hendy:
We really need to present all the information, all the data, and all the options to our patients. It's good to have options. It's not really a good thing to have one option. We cannot say one option as an option. So I would encourage my colleagues caring for reproductive-age women suffering from uterine fibroids to offer them all the options and then together find the best option for this particular patient so she is satisfied with the outcome of the treatment.

Dr. Turck:
Well, with that call to action in mind, I want to thank my guest, Dr. Ayman Al-Hendy, for joining me to discuss how we can overcome common myths and misperceptions in uterine fibroid treatment. Dr. Al-Hendy, it was great having you on the program.

Dr. Al-Hendy:
Thank you so much for having me.

Announcer:
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